Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON ORTHROPAEDIC SURGICAL
5420 WEST LOOP S STE 3600
BELLAIRE TX 77401-2121

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2659-01

MFDR Date Received
April 17, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Payment is due for under payment CPT 63685 should have been paid at 100% of APC rate."

Amount in Dispute: $14,396.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2011	Outpatient Hospital Services	$14,396.18	$14,396.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.
   - 197 – RECOMMENDED ALLOWANCE BASED ON NEGOTIATED DISCOUNT/RATE.
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - OA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUNDLING OF SERVICES.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced/denied payment for disputed services with reason codes 131 – "CLAIM SPECIFIC NEGOTIATED DISCOUNT" and 197 – "RECOMMENDED ALLOWANCE BASED ON NEGOTIATED DISCOUNT/RATE." Per Labor Code §413.011(d-6), the provisions that authorized insurance carriers to contract with health care providers for fees that are different from those specified by the Division's fee guidelines expired on January 1, 2011. No information was found to support that the services in dispute are subject to a contractual agreement related to a workers' compensation health care network that had been certified under Insurance Code Chapter 1305. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $55,833.12. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 72070 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.02. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $26.76. The non-labor related portion is 40% of the APC rate or $18.02. The sum of the labor and non-labor related amounts is $44.78. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $44.78. This amount multiplied by 200% yields a MAR of $89.56.
   - Procedure code 76001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 63655 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0061, which, per OPPS Addendum A, has a payment rate of $6,201.79. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,721.07. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $3,684.60. The non-labor related portion is 40% of the APC rate or $2,480.72. The sum of the labor and non-labor related amounts is $6,165.32. The cost of this service does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total APC payment for this service is $6,165.32. This amount multiplied by 200% yields a MAR of $12,330.64.

- Procedure code 63685 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0039, which, per OPPS Addendum A, has a payment rate of $14,743.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $8,846.15. This amount multiplied by the annual wage index for this facility of 0.9902 yields an adjusted labor-related amount of $8,759.46. The non-labor related portion is 40% of the APC rate or $5,897.43. The sum of the labor and non-labor related amounts is $14,656.89. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.206. This ratio multiplied by the billed charge of $25,590.05 yields a cost of $5,271.55. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $14,656.89 divided by the sum of all APC payments is 70.24%. The sum of all packaged costs is $3,078.17. The allocated portion of packaged costs is $2,162.09. This amount added to the service cost yields a total cost of $7,433.64. The cost of this service exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service is $14,656.89. This amount multiplied by 200% yields a MAR of $29,313.78.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

   - "BS PRECISION GENERAT" as identified in the itemized statement and labeled on the invoice as "PRECISION IPG KIT DUAL ARRAY RECHARGABLE" with a cost per unit of $15,250.40;
   - "BS SCS CHARGING SYST" as identified in the itemized statement and labeled on the invoice as "PRECISION CHARGING SYSTEM" with a cost per unit of $2,471.60;
   - "BS PATIENT PROGRAMMI" as identified in the itemized statement and labeled on the invoice as "PATIENT PROGRAMMER KIT" with a cost per unit of $983.28;
   - "BS SURGICAL LEAD" as identified in the itemized statement and labeled on the invoice as "ARTISAN 2X8 LIM, 50CM" with a cost per unit of $5,367.88.

   The total net invoice amount (exclusive of rebates and discounts) is $24,073.16. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,882.28. The total recommended reimbursement amount for the implantable items is $25,955.44.

5. The total allowable reimbursement for the services in dispute is $67,689.42. The amount previously paid by the insurance carrier is $34,479.41. The requestor is seeking additional reimbursement in the amount of $14,396.18. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $14,396.18.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $14,396.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	November 30, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.